8 • Social work

The role of the medical social worker

Our medical social workers provide emotional and practical support to patients and families, anticipatory grief counseling, and information about local resources such as attendant care and Lifeline services.

The medical social worker can help families understand hospice philosophy and Medicare insurance benefits, and will regularly assess practical and psychosocial-spiritual needs to help patients and families cope. Medical social workers specialize in working with family systems and conflict resolution. (See the article at the end of this section, *Family Conflict at the End of Life*.) Medical social workers can also help with Advance Care Directives, funeral and/or memorial planning, and general problem-solving.

Advance Care Planning

Advance care planning is a process that helps people decide and document what kind of care they would want – and what kind they would not want – if they have a health crisis and are not able to communicate or make decisions. The process allows them to identify someone to make medical decisions for them if they are unable to make their own.

Mission Hospice helps people with Advance Care Planning in advance of critical need, through our Take Charge program (MissionHospice.org/TakeCharge).

When a patient is admitted to our care, if they have not already done Advance Care Planning, our Medical Social Workers will help them complete two important legal documents: California Advance Health Care Directive and POLST (Physician Orders for Life-Sustaining Treatment). Both documents are in this handbook.

MISSION HOSPICE & HOME CARE
it's about life

California Advance Health Care Directive

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

About your Advance Health Care Directive

Mission Hospice & Home Care is dedicated to providing you the best care possible in a way that respects your individual needs and choices. In order to do this, we need to be aware of your choices, and to inform you if any of your choices might not be possible for us to meet, given our organization's policies and California state law.

If you have a written Advance Health Care Directive, we request a copy to review and keep for our records. If, after we review your document, any of your wishes conflict with our policies or with CA state law, we will let you know immediately. **If you have not completed a written Advance Health Care Directive and have the legal capacity to do so, we encourage you to complete one now.** We will inform you of any limitations Mission Hospice & Home Care may have in following that Advance Directive.

California law (Health and Safety Code Section 442.5) gives an individual with capacity the right to execute a power of attorney for health care and provides a form for that purpose (see CA Probate Code Section 4670 – 4701.) We have attached a copy of that form, should you choose to use it. California law does not require that you use this form, but the law does specify what is required in order for your written document to be legal. This form meets the legal requirements.

California law also states that you have the right to information and counseling about the Advance Health Care Directive, should you so desire. Please let us know if we can provide you with that counseling, information or with assistance in completing this form. You may also want to consult an attorney for legal advice regarding an Advance Health Care Directive. You are also encouraged to discuss any questions or concerns about completing an Advance Health Care Directive with your physician, family/friends, and particularly with the person you name as your health care agent.

In addition, Mission Hospice & Home Care has adopted the following policy:

> *Mission Hospice & Home Care recognizes that all adults have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of Mission Hospice & Home Care to encourage patients and their family/caregivers to participate in decisions regarding care and treatment. Valid Advance Directives, such as living wills, Durable Powers of Attorney for Health Care, and DNR (Do Not Resuscitate) orders will be followed to the extent permitted and required by law.*
>
> *In the absence of Advance Directives, Mission Hospice & Home Care will provide appropriate care according to the plan of care authorized by the attending physician and the hospice interdisciplinary group and hospice Medical Director. Mission Hospice & Home Care will conform to state laws regarding implementation of an Advance Directive. Mission Hospice & Home Care will not determine the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.*

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

Name _____ **Date of birth** _____

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternative agent: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternative agent: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____ (Add additional sheets if needed.)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

(Initial) _____ My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

OR

(Initial) _____ My agent's authority to make health care decisions for me takes effect immediately.

AGENT'S OBLIGATION:

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life

(Initial) _____ I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

Choice To Prolong Life

(Initial) _____ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if needed.)

OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

PART I. Upon my death:

(Initial) _____ I give any needed organs, tissues, or parts.

OR

(Initial) _____ I do not authorize the donation of any organs, tissues or parts.

OR

(Initial) _____ I give the following organs, tissues, or parts only:

If you wish to donate organs, tissues, or parts, you must complete parts II and III.

PART II. My gift is for the following purposes (initial all that you accept):

_____ Transplant _____ Research _____ Therapy _____ Education

PART III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes (initial your choice): _____ Yes _____ No

2. My donated tissue may be used for applications outside of the United States. _____ Yes _____ No

3. My donated tissue may be used by for-profit tissue processors and distributors. _____ Yes _____ No

(Health and Safety Code Section 7158.3)

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: Phone:

Address:

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: Phone:

Address:

PART 5 – SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

PATIENT

Printed name: Signature:

Address:

Date: Time:

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Printed name: Signature:

Address:

Phone: Date: Time:

SECOND WITNESS

Printed name: _____ Signature: _____

Address: _____

Phone: _____ Date: _____ Time: _____

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration.

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Printed name: _____ Signature: _____

Address: _____

Date: _____ Time: _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California, County of _____

On (date)_____ before me, (name and title of the officer) _____ _____ personally appeared (name(s) of signer(s)) _____ _____ , who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct. WITNESS my hand and official seal.

Signature: _____ [Seal]

PART 6—SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement.

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Printed name: _____ Signature: _____

Address: _____

Date: _____ Time: _____